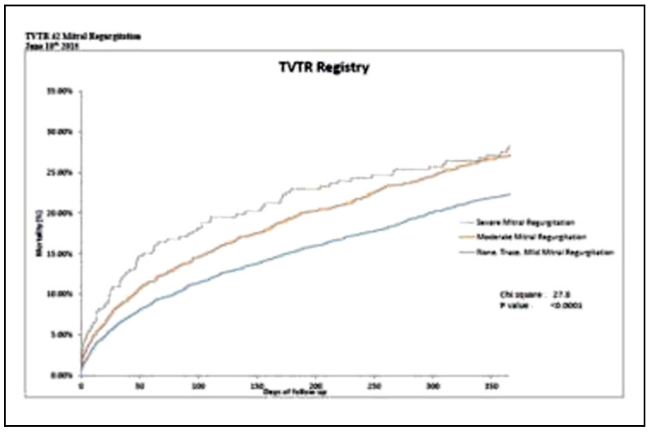
Following TAVR, the majority of these patients have at least one grade improvement in the MR grade prior to discharge. Despite this improvement, 30 day and 1 year mortality is significantly higher in those with moderate or severe MR than those with minimal MR.

	None Trace Mild MR (N=7122)	Moderate MR (N=3497)	Severe MR (N=602)	P value
Age (y)	83	85	86	<0.001
Female (%)	49	56	55	<0.001
DM (%)	38	34	30	<0.001
Prior MI (%)	25	27	25	0.33
Prior CABG (%)	33	32	20	0.39
Home O2 (%)	15	13	11	0.003
Chronic lung disease, severe	14	13	12	0.003
Atrial fibrillation (%)	37	47	53	<0.001
AVG mean mmHg	44	43	43	0.006
PASP mmHg	43	49	52	<0.001
PCWP mmHg	18	20	22	<0.001
LVEF (%)	59	55	53	<0.001
Femoral access (%)	56	57	59	0.36
Device success (%)	92	91	92	0.89



CATEGORIES STRUCTURAL: Valvular Disease: Aortic

TCT-112

Prasugrel In Clopidogrel Nonresponders Undergoing Percutaneous Coronary Intervention: The REsponsiveness To CLOpidogrel And StEnt Thrombosis (RECLOSE)- 3 Study

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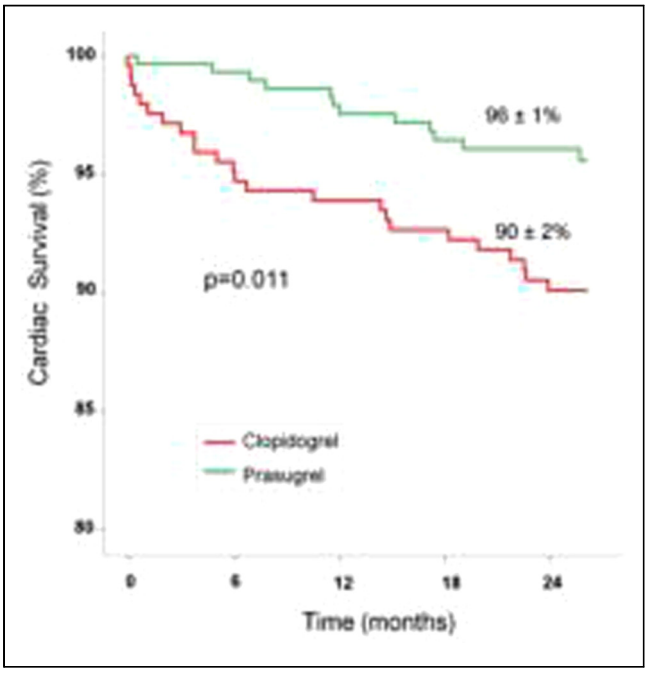
BACKGROUND Clopidogrel nonresponsiveness is a strong marker of the risk of cardiac death and stent thrombosis after percutaneous coronary intervention (PCI). It is unknown if clopidogrel non-resposiveness is a nonmodifiable risk factor or if prasugrel with more potent and predictable platelet inhibition as measured by ex vivo techniques is associated with a positive effect on clinical outcome. This study sought to investigate the efficacy of prasugrel as compared with clopidogrel in clopidogrel nonresponders.

METHODS REsponsiveness to CLOpidogrel and StEnt thrombosis (RECLOSE)- 3 study screened clopidogrel nonresponders after a 600 mg loading dose of clopidogrel. Clopidogrel nonresponders switched to prasugrel (10 mg/daily) the day of PCI, and ADP test (10 μmo/L of ADP) performed 6 days after PCI. The primary end point was 2-year cardiac mortality. Patient outcome was compared with the RECLOSE-2 study.

RESULTS We screened 1,550 patients, and 302 were clopidogrel nonresponders. The ADP test was 77.6 ± 6.2%. After switching to prasugrel the ADP test result was reduced to 47.1 ± 16.8%. The 2-year cardiac mortality rate was 4% in the RECLOSE-3 study and 9.7 % in nonresponders of the RECLOSE-2 study (p = 0.007). The definite/probable stent thrombosis rates were 0.7% and 4.4%, respectively (p = 0.004). At the final multivariable analysis, prasugrel treatment was related to the risk of 2-year cardiac death (HR 0.32, p=0.036) after adjusting for age, ACS and renal insufficiency.



CONCLUSIONS Clopidogrel nonresponsiveness can be overcame by prasugrel (10 mg/daily), and optimal platelet aggregation inhibition on prasugrel treatment is associated with a low rate of long-term cardiac mortality and stent thrombosis.

CATEGORIES CORONARY: Pharmacology/Pharmacotherapy

KEYWORDS Clopidogrel resistance, Prasugrel, Stent thrombosis